

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04616

Reg. Dist. No.

4634

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Grantsville</u>				c. LENGTH OF STAY IN 1b <u>38 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>DECATOR</u> Last <u>BAUM</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 18, 1897</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John H. Baum</u>				14. MOTHER'S MAIDEN NAME <u>Anna Youngerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-16-6172</u>		17. INFORMANT <u>Mrs. Margaret Baum, Grantsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BROKEN NECK BY HANGING</u> DUE TO <u>974x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER JR.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4-24-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u> Grantsville, Md.				24a. REC'D BY REGISTRAR DATE <u>APR 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

APR 30 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 228 5-5-58 et

CERTIFICATE OF DEATH

04617

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUPPETT NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LAURA ESTELLA CARSKADON				4. DATE OF DEATH Month Day Year APRIL 24 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT.-30-1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY ALBRIGHTSVILLE PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES CHRISTMAN				14. MOTHER'S MAIDEN NAME SUSANA ECKARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT FLOYD CARSKADON		Address CRELLIN. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Disease 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 34 years 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/4 , 19 55 , to 4/24 , 19 58 , that I last saw the deceased alive on 4/21 , 19 58 , and that death occurred at 2:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED 24 April 58							
ACTUAL SIGNATURE A. E. Manco				PHYSICIAN'S NAME (Type) A. E. Manco, M.D., Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL-26-1958		22c. NAME OF CEMETERY OR CREMATORY TERRA ALTA CEMETERY		22d. LOCATION (City, town, or county) (State) TERRA ALTA W.V.A.	
23. FUNERAL DIRECTOR'S SIGNATURE Beldon Funeral Home ADDRESS Oakland, Md.				24a. REG'D BY REGISTRAR APR 30 58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. B.

APR 30 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 8,9 Film G229 5-19-58 et

04618

CERTIFICATE OF DEATH

Reg. Dist. No.

4626

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Oakland</u>		<u>3 mo</u>		TOWN <u>Cumberland</u>		<u>01022</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cuppett Nursing Home</u>				STREET ADDRESS (If rural give location) <u>223 Spruce St.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Balford Thomas Grapes</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 30 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 16, 1905</u>	9. AGE last birthday <u>54 53</u> Yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>		11. BIRTHPLACE (State or foreign country) <u>Medley, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph T. Grapes</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Self</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-7296</u>		17. INFORMANT & ADDRESS <u>Mrs Ruth Boyce, Keyser WV</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
581.0 IMMEDIATE CAUSE (A) <u>Cirrhosis of liver</u>						6 mo	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> <u>at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 6, 1958</u> to <u>Apr 30, 1958</u> , that I last saw the deceased alive on <u>Apr 29, 1958</u> , and that death occurred at <u>5:59</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Arthur F. Jones</u>				ADDRESS (Street, city, town, state) <u>Oakland, Md</u>		DATE SIGNED <u>May 2, 1958</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 3, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Meadow Point</u>		LOCATION (City, town, or county) (State) <u>Keyser, West Virginia</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>George K. Chambers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George K. Chambers</u>		ADDRESS <u>Keyser WV</u>	
DATE <u>MAY 6 '58</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1922

Name of Deceased _____ _____ _____		Sex _____		Age _____	
Date of Birth _____		Date of Death _____		Time of Death _____	
Place of Birth _____		Place of Death _____		Cause of Death _____ _____ _____	
Occupation _____		Marital Status _____		Signature of Physician _____ _____	
Signature of Registrar _____ _____		Signature of Coroner _____ _____		Signature of Medical Examiner _____ _____	

DEPARTMENT OF HEALTH

AT THE OFFICE OF THE REGISTRAR, BUREAU OF VITAL STATISTICS, OF THE STATE DEPARTMENT OF HEALTH, AT TOPEKA, KANSAS, THIS _____ DAY OF _____, 1922.

WITNESSES MY HAND AND SEAL OF OFFICE AT TOPEKA, KANSAS, THIS _____ DAY OF _____, 1922.

4627 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Garrett Co., Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>TICE</u> Last <u>HERSHBERGER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Tice</u>		14. MOTHER'S MAIDEN NAME <u>Sara Beachy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Samuel Hershberger, Grantsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January, 1956</u> to <u>March, 1958</u> , that I last saw the deceased alive on <u>March 19, 1958</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ruth Peachey</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Grantsville Md</u> <u>Apr 7/58</u>	
PHYSICIAN'S NAME (Type) <u>Ruth Peachey M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Somerset Co., Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		ADDRESS <u>Grantsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al Hersh</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

APR 9 1958

RECEIVED

4628 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Va. b. COUNTY Grant	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 12 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Rest Home		d. STREET ADDRESS 85 x - 3	
3. NAME OF DECEASED (Type or print) First Sarah Middle Ellen Last King		4. DATE OF DEATH Month April Day 30 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mill Stone, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Gay		14. MOTHER'S MAIDEN NAME Sarah Dawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 232-03-2234	
17. INFORMANT Dorothea Hite, Washington, D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TTA infection 171X DUE TO CARCINOMA OF CERVIX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1951 to 4-30, 1958 , that I last saw the deceased alive on 4-30, 1958 , and that death occurred at 5 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Feaster, Jr.		ADDRESS (Street, city or town, state) 58 21 ST. CARL. MD.	
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR.		DATE SIGNED 4/30/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1958	
22c. NAME OF CEMETERY OR CREMATORY Bayard Cem.		22d. LOCATION (City, town, or county) (State) Bayard, West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas W. Va.		ADDRESS	
24a. REC'D BY REGISTRAR MAY 5 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of New York

County of ...

City of ...

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4629 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Grantsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>J.</u> Last <u>MAUST</u>				4. DATE OF DEATH <u>APRIL</u> Month <u>1</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1872</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Meyersdale, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jones Maust</u>				14. MOTHER'S MAIDEN NAME <u>Barabara Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>John Maust, Grantsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thromboses</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>7-1-57</u> 19 <u> </u> , to <u>4-4</u> 19 <u>58</u> , that I last saw the deceased alive on <u>3-20</u> 19 <u>58</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leonard L. Rock MD</u>		M.D.		ADDRESS (Street, city or town, state) <u>209 North St Meyersdale Pa</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>LEONARD L. ROCK MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grantville</u>		22d. LOCATION (City, town, or county) <u>St. Paul Somerset Co. Pa.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Newman</u>		ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 8 1958</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958

RECEIVED

4630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ACCIDENT		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ACCIDENT	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SIMON EARLE OPEL		4. DATE OF DEATH Month Day Year APRIL 9 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 25, 1892
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) GARRETT Co, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME PETER OPEL		14. MOTHER'S MAIDEN NAME MARY BRENNEMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown; if yes, give war or dates of service)		16. SOCIAL SECURITY NO 190-16-3771	
17. INFORMANT Address Mrs Anna Opel, Accident Md Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 10 minutes			
b) Hypertensive cardiovascular disease 10 years			
c) 44.3X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1957 to April 9, 1958 , that I last saw the deceased alive on April 8, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Paige Strong M.D.		ADDRESS (Street, city or town, state) Salisbury, Penn DATE SIGNED 4/12/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/13/58	22c. NAME OF CEMETERY OR CREMATORY GLADE	22d. LOCATION (City, town, or county) (State) ACCIDENT GARRETT Co MD
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman, Grantville, Md.		24a. REC'D BY REGISTRAR APR 15 '58	24b. REGISTRAR'S SIGNATURE W. S. Beach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938

BUREAU V. S.

APR 15 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04656

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> 4631 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Friendsville)</u> c. LENGTH OF STAY IN 1b <u>8 mos.</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Friendsville, Maryland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>En Route To Garrett C. Me. Hosp., Oak., Md.</u>			d. STREET ADDRESS <u>Friendsville, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lucinda</u> Middle <u>Sendie</u> Last <u>Savage</u>			4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>19 58</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 7th., 1957</u>	9. AGE (In years last birthday) <u>0</u> mos.	IF UNDER 1 YEAR <u>0</u> months <u>17</u> days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Oakland, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Foster Savage</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Foster Savage Rt. 1 Friendsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of vomitus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial pneumonia, C. U.</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u> <u>one week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James H. Feaster, Jr., M.D.</u> EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>4-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bloomington Rose Crm.</u>	22d. LOCATION (City, town, or county) (State) <u>Friendsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Markleyburg Pa</u>			24a. REC'D BY REGISTRAR <u>APR 21 1958</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

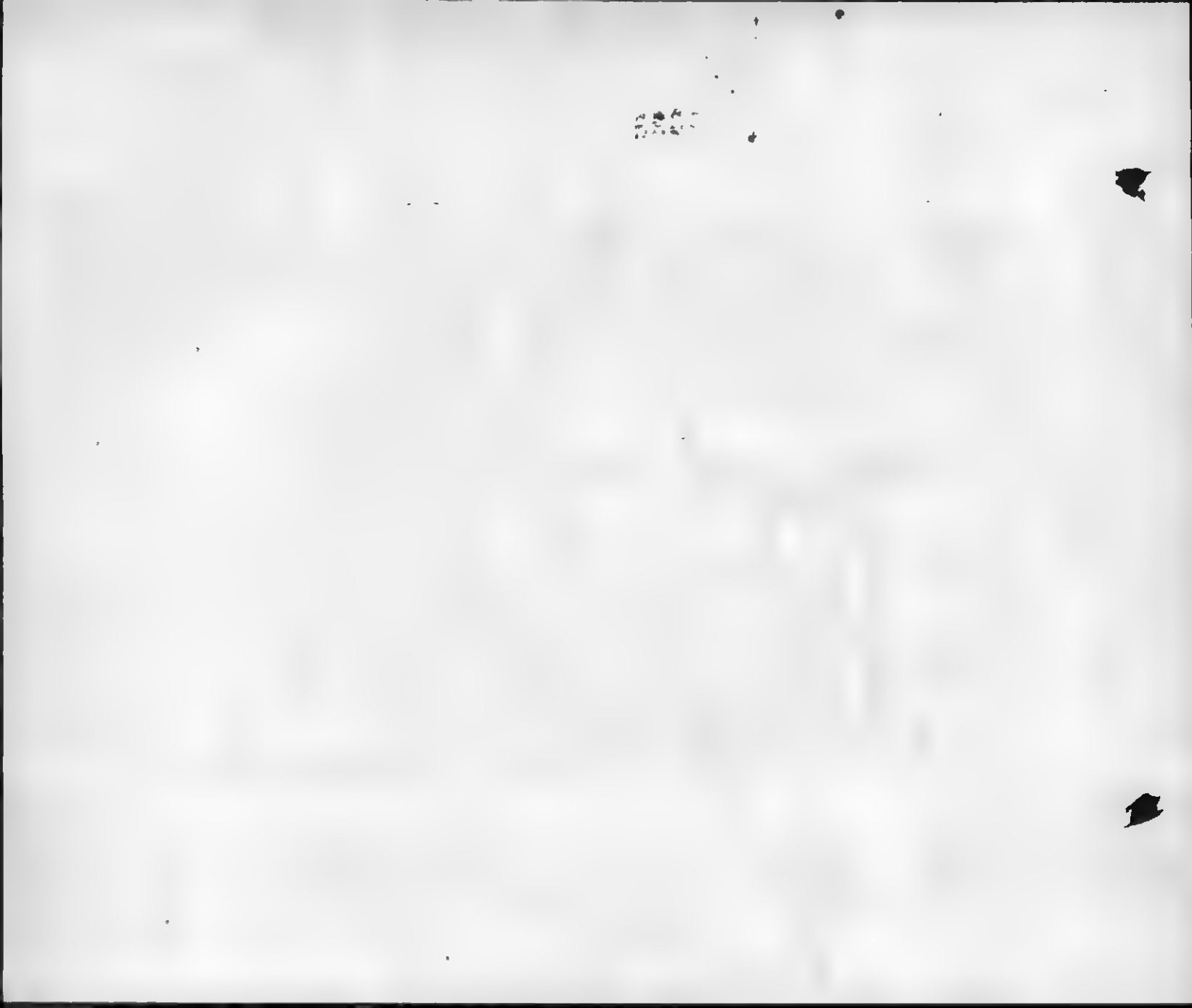
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u> c. LENGTH OF STAY IN lb <u>58 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>---</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u> d. STREET ADDRESS <u>---</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Orval</u> <u>Clarence</u> <u>Sliger</u>		4. DATE OF DEATH Month Day Year <u>April 27,</u> <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>July 2, 1899</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Sliger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Uphold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT Address <u>Benjamin Sliger Friendsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER, JR. M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-28-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Steele Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Friendsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. C. Leighton</u> <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '58</u>	
24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4633 CERTIFICATE OF DEATH

Reg. Dist. No.

04658

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,		c. LENGTH OF STAY IN 1b 20 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park		d. STREET ADDRESS 2 Mi. West of Deer Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2 Mi. West of Deer Park		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Levi Middle Alvin Last Smith		4. DATE OF DEATH Month April Day 21 , Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 9, 1874
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. BIRTHPLACE (State or foreign country) Maryland
10b. KIND OF BUSINESS OR INDUSTRY Own Farm		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eli Smith		14. MOTHER'S MAIDEN NAME Nancy Hoop	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220 03 7463	
17. INFORMANT Troy Smith		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease DUE TO (c) 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1957 to April 21, 1958 , that I last saw the deceased alive on April 21, 1958 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton M.D.		ADDRESS (Street, City or town, State) 77 Oak St. Oakland Md.	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		DATE SIGNED Apr 23 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/1958	
22c. NAME OF CEMETERY OR CREMATORY Ferndale Church Cemetery		22d. LOCATION (City, town, or county) (State) near Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE APR 26 1958		24b. REGISTRAR'S SIGNATURE W. H. Smith	

UREAU V. S.

APR 8 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4634 Item 2 Film 2228 5-12-58 et
CERTIFICATE OF DEATH

04659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett Alleg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>17 Hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>		e. STREET ADDRESS <u>Frostburg, Rt. # 2, Box 83</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Truly</u> Last <u>Truly</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-84</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Railroad</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Truly</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Thompson Margaret Graham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>712-14-1618</u>	
17. INFORMANT Address <u>Route 2 Box 84 Frostburg, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA, Hypostatic</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>90L9</u> (b) <u>Arterio Sclerotic Cardio-Respiratory disease</u> DUE TO (c) <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Rt. Femur 4-15-58 - Pinned 4-15-58 in Recovery</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-15</u> , 19 <u>58</u> , to <u>4-30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-29-58</u> , and that death occurred at <u>7:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u> M.D. <u>58 24 St. Oakland Md</u>		DATE SIGNED <u>4-30-58</u>	
PHYSICIAN'S NAME (Type) <u>James H. Feaster Jr., M.D.</u> <u>Oakland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-3-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Pk.</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Mattingly</u>		24c. REGISTRAR'S SIGNATURE <u>W. H. Mattingly</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

4635

CERTIFICATE OF DEATH

Reg. Dist. No.

04660

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Mineral			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 18 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reeces Mill 85x3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clellie Middle Victoria Last Umstot				4. DATE OF DEATH Month April Day 5 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1884		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maysville, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Haslacker				14. MOTHER'S MAIDEN NAME Elizabeth Hesse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Homer Furell, Westport, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Infected Decubiti & Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Vascular Disease DUE TO 10-15 yrs. (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Dementia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 27, 1957 to April 1958 , that I last saw the deceased alive on March 25, 1958 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert A. Leighton M.D.				ADDRESS (Street, city or town, state) 77 Oak Street Oakland, Md. DATE SIGNED April 11, 1958			
PHYSICIAN'S NAME (Type) Herbert Leighton, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 8, 1958		22c. NAME OF CEMETERY OR CREMATORY Mineral Baptist		22d. LOCATION (City, town, or county) (State) Reeces Mill W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Rogers Funeral Home Inc.				ADDRESS Keyser W. Va.		24a. REC'D BY REGISTRAR DATE APR 11 '58	
				24b. REGISTRAR'S SIGNATURE W. H. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE AND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

15

RECEIVED
 APR 11 1958
 BUREAU V. S.